Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUMMIT REHABILITATON CENTERS
C/O THE MORRIS LAW FIRM
702 S BECKLEY AVE
DALLAS TX 75203

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-07-1444-01

MFDR Date Received

November 9, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Provider sent a request for reconsideration on October 06, 2006. Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule."

Amount in Dispute: $1,582.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim was initially denied, but later accepted per an agreement approved on 09/13/06. Preauthorization was not obtained for the physical therapy rendered after the 14 days post injury exception; therefore physical therapy was not paid. Office visits were paid as well as the FCE and the physical therapy up until 02/18/06. The Physical therapy after 02/04/06 was denied. Codes 95833 and 95851 were denied as being global to the office visits, per NCCI edit. Code 96004 was denied as being global to the office visits per NCCI edits as is fro interpretation of computerized data. This should be included as part of the testing."

Response Submitted by: Employers Claims Adjustment Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2006	95831, 95833, 95851, 96004	$297.31	$0.00
February 20, 2006	97012, 97110, 97116, 97140, G0283	$207.27	$0.00
February 22, 2006	97110, 97116, G0283	$154.64	$0.00
February 24, 2006	97140, G0283	$48.28	$0.00
March 2, 2006	97012, 97110, 97116, 97140, G0283	$200.86	$0.00
March 3, 2006	97012, 97116, 97140	$81.73	$0.00

March 6, 2006	95833, 95851, 96004, 97110, 97116, 99213, G0283	$441.75	$0.00
March 14, 2006	96004	$150.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code § 134.600, effective May 2, 2006, requires preauthorization for physical therapy services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 30, 2006
   - W3 – Additional payment made on appeal/reconsideration
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration
   - 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
   - W2 – Worker's Compensation adjudicated as non-compensable. Carrier not liable for claim or service/treatment. Entitlement to benefits (non-compensable)

Issues

1. Did the requestor submit an updated table?
2. Did the requestor submit documentation to support preauthorization was obtained for the disputed dates of service in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. The original disputed amount was $2,622.30. On August 27, 2008 the healthcare provider submitted an updated table with a disputed amount of $1,582.79.
2. Per Rule §133.307(a)(2) "In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules."
3. Per Rule §134.600 "(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the."
4. Per Rule §134.600 (p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning; (iii) Orthotics/Prosthetics Management(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code..."
5. Review of the submitted documentation finds that the requestor did not obtain preauthorization as required by Rule §134.600 for the disputed dates of service, therefore reimbursement cannot be recommended.
6. Review of the submitted EOB dated 10/6/2006 indicates that payment was issued for CPT code 99213 rendered on March 6, 2006, therefore no further reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 15, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.